Nigeria

The following provides a summary of specific guidelines from the country's national TB guidance strategy. Use the jump links in yellow to access details on case definitions, diagnostic methods, standard protocols, and DOTS recommendations. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be found below the jump links for download.

Patient Population **Download summary page as PDF** **E-mail this page**
Suggest Updates

- Adults
- Children

Adults

Year Issued:

2010

TB Screening Frequency for PLHIV:

Contacts of all smear-positive PTB patients should be invited to the health facility to be screened for TB.

These are:

- All adult contacts who are coughing for 2 weeks or more
- Those with known positive HIV status (with or without cough)

Record should be kept of these contact persons in an exercise book.

Screening Recommendations during TB Treatment:

Follow-up of Patients using Sputum Microscopy

Two sputum smear examinations (taken as two early morning samples within 2 days) are done at different points during treatment:
For smear positive patients, collect and examine sputum at:
end of the 2nd month for new cases or
3rd month for re-treatment cases
end of 5th month
end of 6th months for six months regimen and end of 7th month for eight month regimen

For smear negative patients:
collect and examine sputum only at the end of the 2nd month.
All sputum samples are to be collected one week prior to the end of the month specified above.

If a patient no longer produces sputum, but saliva instead, the laboratory should examine these materials for AFB.

Case definition:

Any person coughing for 2 weeks or more, with or without the following symptoms should be suspected of PTB:

- Weight loss
- Tiredness
- Fever
- Night sweats
- Chest pain
- Shortness of breath
- Loss of appetite
- Coughing up blood

If at least two sputum specimens are positive for acid-fast bacilli (AFB), the patient is classified as smear-positive TB.

HIV positive clients with one sputum sample positive should be considered as TB cases.

HIV positive clients with three smear negatives samples should be referred to medical officer immediately for further evaluation (using X-ray).

Diagnostic methods:

The diagnosis of tuberculosis rests mainly on the identification of the tubercle bacilli by sputum smear microscopy. Any individual suspected of having Tuberculosis disease should be requested to submit three (3) sputum samples for examination.

Standard TB Treatment Protocols:

Category 1 regimen Adult:
(2RHZE/6EH or 2RHZE /4RH) for new cases (CAT 1)

Category 2 regimen Adult:
(2SRHZE/1RHZE/5RHE) for relapses, failures, RAD and others - Retreatment chemotherapy (CAT 2)

New Case (N): A patient who has never had treatment for TB or who has taken anti-TB drugs for less than four weeks.

Relapse (R): A TB patient who previously received treatment and was declared cured or completed a full course of treatment and has once again developed sputum smear-positive TB

Treatment failure (F): A smear positive patient who while on treatment remained, or became smear positive again five months or later after commencement of treatment

Return after default (RAD): A TB patient who completed at least four weeks of Category 1 treatment and returned smear positive after at least 8 weeks of interruption of treatment

Transfer in (T.I.):A TB patient already registered for treatment in one LGA/State who is transferred to another LGA/State where s/he continues treatment.

Other (O):A TB patient who does not fit into one of the above case definitions.

DOTS Recommendations:

Effective treatment is achieved through Directly Observed Treatment (DOT), which means that the patient swallows the tablets under the supervision of a health worker or designated treatment supporter (family or community member). Therefore the health workers should ensure that patients receive treatment in health facilities closest to the patient's home. Refer if necessary. A TB suspect should report to the DOTS centre for diagnosis by the DOTS provider.

Following diagnosis, a community health worker at the DOTS centre will work in collaboration with the community volunteer to identify an acceptable treatment supporter for the patient. The treatment supporter should support and encourage the patient to commence and complete his/her treatment.

Children

Year Issued:

2010

TB Screening Frequency for PLHIV:

Contacts of all smear-positive PTB patients should be invited to the health facility to be screened for TB. These are:

- Those with known positive HIV status (with or without cough)
- All children of the household (including children born while on treatment)

Record should be kept of these contact persons in an exercise book.

Screening Recommendations during TB Treatment:

Follow-up of Patients using Sputum Microscopy

Two sputum smear examinations (taken as two early morning samples within 2 days) are done at different points during treatment:

For smear positive patients, collect and examine sputum at:
end of the 2nd month for new cases or
3rd month for re-treatment cases
end of 5th month
end of 6th months for six months regimen and end of 7th month for eight month regimen

For smear negative patients:
collect and examine sputum only at the end of the 2nd month.
All sputum samples are to be collected one week prior to the end of the month specified above.

If a patient no longer produces sputum, but saliva instead, the laboratory should examine these materials for AFB.

Case definition:

Tuberculosis should be suspected in children with any or combination of the following symptoms:

- Low grade fever not responding to malaria treatment
- Night sweats
- Loss of weight
- Loss of appetite
- Failure to thrive

- Lymph node swellings
- Joint or bone swellings
- Angle deformity of the spine
- Listlessness
- Neck stiffness, headache, vomiting (TB meningitis)

Any child suspected of having TB should be referred to a Medical Officer for diagnosis.

Use of Score Chart for the Diagnosis of Tuberculosis in Children:
A score of 7 or more indicates a high likelihood of tuberculosis

Diagnostic methods:

The diagnosis of TB in children can be very difficult owing to the wide range of symptoms. Sputum cannot often be obtained from children and in any case it is often negative even on culture. Symptoms in children are not typical. The diagnosis should therefore be based on clinical findings (especially failure to thrive or weight loss), family history of contact with a smear positive case, X-ray examination and tuberculin testing, culture (if available and non-response to broad spectrum antibiotic treatment. A score chart below can help to reach the diagnosis of tuberculosis. Older children who are able to cough up sputum should go through the same assessment as adults using smear microscopy as the "gold standard".

General Features: Duration of illness, failure to thrive or weight loss, TB contact, Tuberculin test, malnutrition, chronic infant disease.

Local Features: chest x-ray, lymph nodes, swelling of bone or joint, ascites, meningitis, angle deformity of spine.

Standard TB Treatment Protocols:

Category 1 regimen Children:
(2RHZ/4RH) for new cases (CAT 1)

Category 2 regimen Children:
(2SRHZE/1RHZE/5RHE) for relapses, failures, RAD and others- Retreatment chemotherapy (CAT 2)

New Case (N): A patient who has never had treatment for TB or who has taken anti-TB drugs for less than four weeks.

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swallows the tablets under the supervision of a health worker or designated treatment supporter (family or community member). Therefore the health workers should ensure that patients receive treatment in health facilities closest to the patient‟s home. Refer if necessary. A TB suspect should report to the DOTS centre for diagnosis by the DOTS provider. Following diagnosis, a community health worker at the DOTS centre will work in collaboration with the community volunteer to identify an acceptable treatment supporter for the patient. The treatment supporter should support and encourage the patient to commence and complete his/her treatment.
